EXHIBIT

A

HEALTH NET OF NEW JERSEY, INC.

HMO - POS PLAN

SMALL GROUP HEALTH MAINTENANCE ORGANIZATION (HMO) POINT OF SERVICE (POS) EVIDENCE OF COVERAGE

Health Net certifies that the Employee named below is entitled to the services, supplies and benefits described in this Evidence of Coverage, as of the Effective Date shown below, subject to the eligibility and effective date requirements of the Contract.

The Contract is an agreement between Health Net and the Contractholder. This Evidence of Coverage is a summary of the Contract provisions that affect Your coverage. All coverage is subject to the terms and conditions of the Contract.

HMO/POS-EOC

OVERVIEW OF THE PLAN (Copayment, Deductibles, and Coinsurance)

NETWORK	
Copayment	$30, unless otherwise stated
Emergency Room Copayment	$100, credited toward Inpatient admission if admitted within 24 hours
Coinsurance	0%

NON-NETWORK	
Calendar year Cash Deductible (All Cause)	
for Preventive Care	NONE
for immunizations and lead screening for children	NONE
for all other Covered Charges	
Per Covered Person	$1,000
Per Covered Family	$2,000 NOTE: Must be individually satisfied by 2 separate Members
Emergency Room Copayment (waived if admitted within 24 hours)	$100
Coinsurance	30%
Non-Network Maximum Out of Pocket	$4,000

MAXIMUM LIFETIME BENEFITS	
NETWORK	Unlimited, **except** as otherwise stated
NON-NETWORK	$5,000,000 per Member, **except** as otherwise stated

treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval by one of the federal entities identified in item a. A cost-benefit analysis of clinical trials will be performed when such an evaluation can be included with a reasonable expectation of sound assessment.

BIOLOGICALLY-BASED MENTAL ILLNESS. A mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to: schizophrenia; schizoaffective disorder; major depressive disorder; bipolar disorder; paranoia and other psychotic disorders; obsessive-compulsive disorder; panic disorder and pervasive developmental disorder or autism.

BIRTHING CENTER. A Facility which mainly provides care and treatment for women during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. It must:

a) provide full-time Skilled Nursing Care by or under the supervision of Nurses;
b) be staffed and equipped to give emergency care; and
c) have written back-up arrangements with a local Hospital for emergency care.

It must:

a) carry out its stated purpose under all relevant state and local laws; or
b) be approved for its stated purpose by the Accreditation Association for Ambulatory Care; or
c) be approved for its stated purpose by Medicare.

A Facility is not a Birthing Center, for the purpose of the Contract, if it is part of a Hospital.

BOARD. The Board of Directors of the New Jersey Small Employer Health Benefits Program.

CALENDAR YEAR. Each successive twelve-month period starting on January 1 and ending on December 31.

CARE MANAGER. An entity designated by Us to manage, assess, coordinate, direct and authorize the appropriate level of health care treatment.

CASH DEDUCTIBLE or DEDUCTIBLE. The amount of Covered Charges that a Member must pay before the Contract pays any benefits for such charges. Cash Deductible does not include Coinsurance, Copayments, and Non-Covered Services and Supplies and Non-Covered Charges. See the **Cash Deductible** section of the Contract for details.

CHURCH PLAN. Has the same meaning given that term under Title I, section 3 of Pub.L.93-406, the "Employee Retirement Income Security Act of 1974"

COINSURANCE. The percentage of Covered Services or Supplies or the percentage of Covered Charges, as applicable, that must be paid by a Member. Coinsurance does **not** include the Cash Deductible, Copayments, or Non-Covered Services and Supplies and Non-Covered Charges.

CONTRACT. The Contract, including the application and any riders, amendments or endorsements, between the Contractholder and Us.

CONTRACTHOLDER. Employer or organization which purchased the Contract.

COPAYMENT. A specified dollar amount which Member must pay for certain Covered Services or Supplies or Covered Charges. ***NOTE:*** *The Emergency Room Copayment, if applicable, must be paid in addition to any other Copayments, Cash Deductible, and Coinsurance.*

COSMETIC SURGERY OR PROCEDURE. Any surgery or procedure which involves physical appearance, but which does not correct or materially improve a physiological function and is not Medically Necessary and Appropriate.

COVERED CHARGES. Reasonable and Customary charges for the types of services and supplies described in the **Covered Charges** and **Covered Charges with Special Limitations** section of the Contract, as applicable to Non-Network benefits. The services and supplies must be:

a) furnished or ordered by a health care Provider; and
b) Medically Necessary and Appropriate to diagnose or treat an Illness or Injury.

A Covered Charge is incurred on the date the service or supply is furnished. Subject to all of the terms of the Contract, We pay benefits for Covered Charges incurred by a Member while he or she is covered by the Contract. Read the entire Contract to find out what We limit or exclude.

COVERED EMPLOYEE. A person who meets all applicable eligibility requirements, enrolls hereunder by making application, and for whom premium has been received.

COVERED SERVICES OR SUPPLIES. The types of services and supplies described in the **Covered Services and Supplies** section of the Contract, as applicable to Network benefits.

Read the entire Contract to find out what We limit or exclude.

CREDITABLE COVERAGE. With respect to an Employee or Dependent, coverage of the Employee or Dependent under any of the following: a Group Health Plan; a group or individual Health Benefits Plan; Part A or Part B of Title XVIII of the federal Social Security Act (Medicare); Title XIX of the federal Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of Title XIX of the federal

purposes of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

A Dependent is not a person who is on active duty in the armed forces of any country.

A Dependent is not a person who is covered by the Contract as an Employee.

At Our Discretion, We can require proof that a person meets the definition of a Dependent.

DEPENDENT'S ELIGIBILITY DATE.
The later of:
a) the Employee's Eligibility Date; or
b) the date the person first becomes a Dependent.

DEVELOPMENTAL DISABILITY or DEVELOPMENTALLY DISABLED. A severe, chronic disability that:
a) is attributable to a mental or physical impairment or a combination of mental and physical impairments;
b) is manifested before the Member attains age 19;
c) is likely to continue indefinitely;
d) results in substantial functional limitations in three or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; economic self-sufficiency;
e) reflects the Member's need for a combination and sequence of special interdisciplinary or generic services, individualized support, and other forms of assistance that are lifelong or of extended duration and are individually planned and coordinated.

DIAGNOSTIC SERVICES. Procedures ordered by a Provider because of specific symptoms to diagnose a specific condition or disease. Some examples include, but are not limited to:
a) radiology, ultrasound, and nuclear medicine;
b) laboratory and pathology; and
c) EKGs, EEGs, and other electronic diagnostic tests.

With respect to Non-Network benefits, **except** as allowed under the Preventive Care Covered Charge, Diagnostic Services are not covered under the Contract if the procedures are ordered as part of a routine or periodic physical examination or screening examination.

DISCRETION / DETERMINATION / DETERMINE. Our sole right to make a decision or determination. The decision will be applied in a reasonable and non-discriminatory manner.

DURABLE MEDICAL EQUIPMENT. Equipment We Determine to be:

f) furnished within the framework of generally accepted methods of medical management currently used in the United States.

In the instance of an Emergency, with respect to Network services and supplies, and in all instances with respect to Non-Network benefits, the fact that an attending Practitioner prescribes, orders, recommends or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate.

MEDICAID. The health care program for the needy provided by Title XIX of the United States Social Security Act, as amended from time to time.

MEDICARE. Parts A and B of the health care program for the aged and disabled provided by Title XVIII of the United States Social Security Act, as amended from time to time.

MEMBER. An eligible person who is covered under the Contract (includes Covered Employee and covered Dependents, if any).

MENTAL HEALTH CENTER. A Facility that mainly provides treatment for people with mental health problems. It will be considered such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) accredited for its stated purpose by the Joint Commission;
b) approved for its stated purpose by Medicare; or
c) accredited or licensed by the State of New Jersey to provide mental health services.

NETWORK PROVIDER. A Provider which has an agreement directly or indirectly with Us to provide Covered Services or Supplies. The Employee will periodically be given up-to date lists of Network Providers. The up-to date lists will be furnished automatically, without charge.

NEWLY ACQUIRED DEPENDENT. An eligible Dependent an Employee acquires after he or she already has coverage in force for Initial Dependents.

NICOTINE DEPENDENCE TREATMENT. "Behavioral Therapy," as defined below, and Prescription Drugs which have been approved by the U.S. Food and Drug Administration for the management of nicotine dependence.

For the purpose of this definition, covered "Behavioral Therapy" means motivation and behavior change techniques which have been demonstrated to be effective in promoting nicotine abstinence and long term recovery from nicotine addiction.

NON-BIOLOGICALLY-BASED MENTAL ILLNESS. An Illness which manifests symptoms which are primarily mental or nervous for which the primary treatment is psychotherapy or psychotropic medication where the Illness is not biologically-based.

- The American Hospital Formulary Service Drug Information;
- The United States Pharmacopeia Drug Information; or

c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes Medically Necessary and Appropriate services associated with the administration of the drugs.

In no event will We pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or

b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

PREVENTIVE CARE. Services and supplies in connection with routine physical examinations, including laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening and Nicotine Dependence Treatment.

PRIMARY CARE PHYSICIAN (PCP). A Network Practitioner who is a doctor specializing in family practice, general practice, internal medicine, obstetrics/gynecology for pre and post-natal care, birth and treatment of the diseases and hygiene of females, or pediatrics who supervises, coordinates, arranges and provides initial care and basic medical services to a Member; initiates a Member's Referral for Specialist Services; and is responsible for maintaining continuity of patient care.

PRIVATE DUTY NURSING. Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

PROVIDER. A recognized Facility or Practitioner of health care.

REASONABLE and CUSTOMARY. With respect to Network services and supplies, the negotiated arrangement.

With respect to Non-Network benefits, an amount that is not more than the usual or customary charge for the service or supply as We Determine, based on a standard approved by the Board. The Board will decide a standard for what is Reasonable and Customary for the Non-Network benefits under the Contract. The chosen standard is an amount which is most often charged for a given service by a Provider within the same geographic area. For charges that are not determined by a negotiated fee schedule, the Member may be billed for the difference between the Reasonable and Customary charge and the charge billed by the Provider.

Please note: The Coordination of Benefits and Services provision includes a distinct definition of Reasonable and Customary.

treatment was recommended or received during the six months immediately preceding the Enrollment Date.

We do not pay benefits for charges for Pre-Existing Conditions for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Member was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Member. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions or pregnancy, or birth defects in a covered Dependent child. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And We waive this limitation for a Member's Pre-Existing Condition if the condition was payable under Creditable Coverage which covered the Member right before the Member's coverage under the Contract started. The next section shows other exceptions.

Continuity of Coverage

If a new Member was covered under Creditable Coverage prior to enrollment under the Contract and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under the Contract, We will provide credit as follows. We give credit for the time the Member was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage. We count the days the Member was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. We apply these days to reduce the duration of the Pre-Existing Condition limitation under the Contract. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Any condition arising between the date his or her coverage under the Creditable Coverage ends and the Enrollment Date is a Pre-Existing condition. We do not cover any charges actually incurred before the person's coverage under the Contract starts. If the Policyholder has included an eligibility waiting period in the Contract, an Employee must still meet it, before becoming covered.

With respect to Network services and supplies, any service provided without prior Referral by the Member's **Primary Care Physician** except as specified in the Contract.

Services related to **Private Duty Nursing** care, except as provided in the Home Health Care sections of the Contract.

Services or supplies that are not furnished by an eligible **Provider.**

The amount of any charge which is greater than a **Reasonable and Customary Charge** with respect to Network services and supplies provided in the event of an Emergency, and with respect to all Non-Network benefits.